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National Rural Health Association
Written Testimony
By
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for the
Health Subcommittee of the
House Committee on Veterans' Affairs
Oversight Hearing on "Access to VA Health Care:
How Easy is it for Veterans? Addressing the Gaps"
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The NRHA is a national nonprofit, non partisan, membership organization with approximately 12,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

I am Andy Behrman, President and Chief Executive Officer of the Florida Association of Community Health Centers, and the chair of the NRHA Rural Health Policy Board. I am also a veteran of the United States Navy. On behalf of the Association, I appreciate the opportunity to testify before this Committee.

The members of the National Rural Health Association have maintained a special concern for the health and mental health care needs of rural veterans for many years. The NRHA was one of the first non-veteran service organizations to develop a policy statement on rural veterans and this policy work is evidence of our memberships' concern for rural veterans.

My testimony discusses current VA successes in providing quality care for rural veterans, and suggestions for further improvements in quality of care. NRHA respectfully requests that the Committee give consideration to the following steps that would improve quality and access to care for rural veterans:

1. Increase the numbers of Veteran Centers, Outreach Health Centers, and Community Based Outreach Centers (CBOCs) in rural areas.

2. Increase health care access points for rural veterans by building upon current successes of both VA service approaches and existing rural health approaches. Fully implement the contracting of services from the VA to Federally Qualified Health Centers (FQHCs) in rural areas. Develop approaches to link VA services and quality to existing rural health providers willing to provide care to rural veterans that follow standards of care and evidence-based medicine, including Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and mental health providers.
3. Increase the number of Veterans Hospital Administration Traumatic Brain Injury Case Managers in predominately rural states.
4. Use the high quality VA system to provide targeted and culturally competent care to rural, minority, and female veterans and train future rural health providers in these rural VA facilities.
5. Fully implement the functions of the newly created Office of Rural Veterans and establish a national advisory committee on rural veterans.

The following is additional background information and discussion of our recommendations.

Overview

Since the founding of our country, rural Americans have always responded when our nation has gone to war. Whether motivated by their values, patriotism, and/or economic concerns, the picture has not changed much in 230 years. Rural individuals - - along with American Indians, urban African Americans and Hispanics - - serve at rates higher than their proportion of the population. Though only 19% of the nation lives in rural America, 44% of U.S. Military recruits come from rural areas and nearly one-third of those who died in Iraq are from small towns and communities across the nation. [1]

Where in rural America are veterans from? According to the most recent census, rural and non-metropolitan counties reported the highest concentration of veterans in the civilian populations aged 18 and over. [2, 3] The proportion of veterans living in rural areas in 18 states is higher than the national average of 12.7 percent. These high-concentration states span the country, and include such geographically varied states as Montana (16.2%), Nevada (16.1%), Wyoming (16%), Maine (15.9%), West Virginia (14.4%), Arkansas (14.2%), South Carolina (14.2%), and Colorado (14.1%). [4]

The disproportionate number of rural Americans serving in the military has created a disproportionate need for veteran's care in rural areas and yet rural areas are less likely to have VA services available to them. [5] More than 22,000 soldiers have been wounded in Iraq. For those wounded veterans returning to their rural homes across the country, access to the specialized services they will need may be limited. Often access to the most basic primary of care is more difficult in rural America. Combat soldiers who need specialized care to assist with their readjustment to civilian life or adaptation to living with war injuries (both physical and mental) will likely find access to that care extremely limited. [6]

It is also important to note that both differences and disparities exist in the health status of rural and urban veterans. The Veterans Administration's Health Services and Outreach Network has reported that rural veterans "have worse physical and mental health" than their urban counterparts and concluded that "policy makers should anticipate greater health care demand from rural populations…" [7]

There is a national misconception that all veterans have access to comprehensive care because they are served by the Veterans Administration. [8] While this may be true for many veterans, it is not true for many small town veterans, rural veterans or those veterans who choose to be isolated due to the complicated symptoms of Post Traumatic Stress Disorder. [9] The Veterans Hospital Administration (VHA) provided care to 4.5 million of the 7.2 million enrolled veterans in fiscal year 2003. While the quality of VHA care is equivalent to, or better than, care in other systems[10], it often is not accessible to many rural and frontier veterans.

While the NRHA is pleased that both the House and Senate FY 2008 budgets call for greater increases in VA medical care spending than in past years, we all must be mindful that appropriations for the last decade have not kept up with the cost of maintaining current services.[11] Policy-makers must not only make up for past funding deficits, they must appropriately plan for long-term funding - - because the wounded soldiers who return today won't need care for just the next few fiscal years, they will need care for the next half century. [12]

NRHA RECOMMENDATIONS:

1. Increase Health Care Access Points for Rural Veterans to Build on Current Successes

NRHA recognizes and appreciates the successes of veteran centers and health care outreach centers in meeting the needs of rural veterans. We should seize the opportunity to build upon this success and further improve quality of and access to care.

Community Based Outreach Centers (CBOCs) open the door for many veterans to obtain primary care services within their home community. While outcomes research on CBOCs is mixed, some findings suggest that CBOCs have been successful in improving geographic access, an important objective of expanding community-based care to veterans."[13] The VHA has improved procedures for planning and activating CBOCs and established consistent criteria and standard expectations for the over 450 CBOCs created since 1995.[14] CBOCs have also been successful in some states, such as West Virginia; however, Directive 2001-06 made this solution less available to more rural and remote veterans and other rural providers by raising the ceiling on the number of priority users in a given area. Outreach Health Centers provide an appropriate model to deal with the loss of CBOC eligibility to smaller and more remote rural areas, and their expansion should be considered. Furthermore, outreach efforts with rural veterans that focus on benefit education and psycho-social education of veterans and their family members can increase the effectiveness of services currently available through the VA system.

2. Increase Health Care Access Points for Rural Veterans to Expand Access

Time and distance prevent many rural veterans from getting their healthcare benefits through a VHA facility. There are approaches readily available in the VA system and in the rural health landscape that could improve this situation. These approaches include Vet Centers, Outreach Health Centers, and CBOCs, as mentioned above, as well as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs), and mental health providers. Policy regarding services to rural veterans needs to provide access through a variety of existing rural health facilities and access points because not all rural communities have access to all types of facilities. Quality through consistent applications of standards of care and evidence-based medicine, however, must guide all approaches to care for rural veterans.

Federally Qualified Community Health Centers (CHCs) serve millions of rural Americans, but most veterans cannot use their VA health benefits to receive care at these CHCs. These centers provide community oriented, primary and preventive health care and are located where rural veterans live. Congress has passed legislation encouraging collaborations (P.L.106-74 and P.L. 106-117 § 102(e), The Veterans Millennium Health Care & Benefits Act). Despite the legislative intent, however, a national policy advocating VHA-CHC collaboration has not emerged in an effective way.

A limited number of collaborations between the VHA and CHCs already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas. Successful contracts exist in Wisconsin, Missouri, and Utah. In other states, contracts were successful but were discontinued for reasons not related to operational success. This model of collaboration between VHA and CHCs might do well in other rural states and with other rural providers and systems of care and should be implemented further.

Critical Access Hospitals provide comprehensive and essential services to rural communities and are specific to rural states. This model provides a great opportunity for policy makers to expand services to rural veterans in communities where CAHs are located. For instance, Montana has 45 Critical Access Hospitals and the highest percentage of veterans in the nation. Working through these existing access points of care in many frontier communities in rural Montana by providing linkages with VA services and models of quality could greatly enhance care for rural veterans.

Designation as a Rural Health Clinic (RHC) provides enhanced reimbursement for Medicare and Medicaid services for private physicians who provide enhanced services to rural communities. RHCs are often physician-owned or sometimes owned by small, rural hospitals, including Critical Access Hospitals. In many rural and frontier communities, RHCs represent the only source of primary care available.

The literature provides much evidence that linking the quality of VA services with civilian services provides opportunities to improve the quality of health care services for all citizens. Linkages can improve the use of evidence based medicine in chronic disease management, in screening and diagnosis, and in treatment of many health conditions. Linkages also provide greater opportunities for the dissemination of VA supported research. These are

additional benefits of any collaboration between VHA and the existing rural health safety net infrastructure.

3. Increase Traumatic Brain Injury Care

Throughout our history all citizens in our nation have benefited from medical research focused on the signature wounds of war. Currently, it appears that Traumatic Brain Injury (TBI) will most likely become the signature wound of the Afghanistan and Iraqi wars. While the VA is gearing up for returning veterans with this condition, the importance of the TBI case manager network and other services in the provision of quality care for these rural veterans cannot be understated.

The Defense and Veterans Brain Injury Network of nine VA and one civilian center provides the needed and highly specialized services that these disabled veterans require. However, only three of these network centers are located in two of the 18 states with high rates of rural veterans, Virginia and Florida. Eleven western states with many rural and frontier veterans, and the other southern states with high numbers of rural veterans have very limited access to these centers once discharged from in patient care. Therefore, the VHA TBI Case Managers Network is vital to these veterans and their families. A review of the number and location of TBI case managers finds them very limited in coverage in states with high numbers of rural veterans -- expansion is needed.

4. Target Care to Rural Veterans

A. **Needs of the Rural Family**. Rural individuals value their families and have strong bonds and ties to their home place and home communities. Our returning veterans adjusting to disabilities and the stresses of combat need the security and support of their families in making their transitions back into civilian life and to manage life style changes due to disabling conditions. The Vet Centers do a tremendous job in assisting veterans with this readjustment, but the demand for services is too great for current funding levels. The NRHA supports increases in funding for counseling services for veterans' families and significant others.

B. **Needs of Rural Women Veterans**. Additionally, the NRHA supports better assessment of the needs of women and minority women veterans. Currently women make up approximately 15 percent of the active military force. Thirty-seven percent of these women are African American. These women serve in all branches of the military, and are eligible for assignment in most military occupational specialties except for direct combat roles. The highest number of women in history to serve in a war zone is currently serving in Iraq and Afghanistan. Our nation is also seeing the highest numbers in history of female wounded and war casualties. [15]

According the Center for Women Veterans, by the year 2010, the women veteran population is projected to be over 10 percent of the total veteran population. The break down on these women by rural and urban residence is not readily available, however, it is reasonable to assume that a higher number of both genders from rural areas go into military service. The VA

is beginning to address changes needed to serve an increased female veteran population, but more can be done. Targeted and culturally competent care for today's women veterans is needed. Additionally, the VA offers a golden opportunity to train rural providers through rural rotations in all VA facilities and programs, thereby exposing our future rural providers to the unique needs of rural, minority, and female veterans.

5. Improve Office of Rural Veterans

The NRHA calls on Congress and the Veterans Administration to fully implement the functions of the newly created Office of Rural Veterans to develop and support an on-going mechanism to study and articulate the needs of rural veterans their families. Additionally, the NRHA supports collaboration of this office with the federal Office of Rural Health Policy within HRSA to better meet the access needs of rural veterans. Finally, the NRHA urges this office to establish a national advisory committee on rural veterans to provide information to policy makers on the needs of this population as it ages.

Conclusion

While NRHA recognizes the purpose of this hearing is not to discuss specific legislation, we do recognize that H.R. 5524, the Rural Veterans Health Care Act of 2006, introduced in the last Congress, includes many of the items long recommended by NRHA. H.R. 5524 calls for expansion and improved quality of services provided by Vet Centers, Outreach Health Centers, and CBOCs in rural areas; a heightened focus on the needs of rural minority veterans; a focus on rural medical education for VA residents, and new research and outreach efforts. We hope similar legislation will again be introduced in the 110th Congress and eventually be enacted into law.

Mr. Chairman, thank you for the opportunity to testify.

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[2] "Veterans: 2000 Census Brief," p. 7.
[3] http://factfinder.census.gov/servlet/SAFFP
[4] "Veterans: 2000 Census Brief," p. 5.
[5] Veterans Health Administration, April 2000, "A Report By The Planning Systems Support Group, A Field Unit of the Veterans Health Administration Office of Policy and Planning-Geographic Access to Veterans Health Administration (VHA) Services in Fiscal Year 2000: A National and Network Perspective.
[6] Alvarez, L. and Lehren, A."3,000th fatality in Iraq, Countless Tears at Home." New York Times. January 2, 2007) Miller, Laura J., June 2001, "Improving Access to Care in the VA Health System: A Progress Report", Forum, A publication of the Veterans Administration Office of Research & Development.
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[9] Sorenson, G., "Hinterlands are home, not a hideaway, for Vietnam veterans," Vet Center Voice, Vol. VI, No. 9, October, 1985, p.1.
[10] The Independent Budget for 2005: Medical Care. Veterans Service Organizations. http://www.pva.org/independentbudget/index.htm
[11] The Independent Budget for 2005: Medical Care. p. 44
[12] The Independent Budget for 2005: Medical Care. p. 45.
[13] Maciejewski, M., et al. CBOC Performance Evaluation Report 2, VA HSR&D, March 2000. http://www.hsrd.research.va.gov/publications/internal/cbocrpt2/cboc_performance_report2.htm
[14] "VHA Handbook 1006.1," April 11, 2003. Department of Veterans Affairs, Veterans Health Administration. Washington, D.C.
[15] news.yahoo.com/s/afp/20070306/lf_afpwomensusirapmilitary_070306170626-33k-March 15, 2007